IC 12-15-44 Version a

Chapter 44. Indiana Check-Up Plan

Note: This version of chapter added by P.L.218-2007, SEC.22. See also following version of this chapter added by P.L.234-2007, SEC.210.

IC 12-15-44-1 Version a

"Plan"

Note: This version of section added by P.L.218-2007, SEC.22. See also following version of this chapter added by P.L.234-2007, SEC.210.

Sec. 1. As used in this chapter, "plan" refers to the Indiana check-up plan established by section 3 of this chapter.

As added by P.L.218-2007, SEC.22.

IC 12-15-44-2 Version a

"Preventative care services"

Note: This version of section added by P.L.218-2007, SEC.22. See also following version of this chapter added by P.L.234-2007, SEC.210.

Sec. 2. As used in this chapter, "preventative care services" means care that is provided to an individual to prevent disease, diagnose disease, or promote good health.

As added by P.L.218-2007, SEC.22.

IC 12-15-44-3 Version a

Plan established; administration; referral of high risk individuals; inapplicability of laws

Note: This version of section added by P.L.218-2007, SEC.22. See also following version of this chapter added by P.L.234-2007, SEC.210.

Sec. 3. (a) The Indiana check-up plan is established.

(b) The office shall administer the plan.

(c) The department of insurance and the office of the secretary shall provide oversight of the marketing practices of the plan.

(d) The office shall promote the plan and provide information to potential eligible individuals who live in medically underserved rural areas of Indiana.

(e) The office shall, to the extent possible, ensure that enrollment in the plan is distributed throughout Indiana in proportion to the number of individuals throughout Indiana who are eligible for participation in the plan.

(f) The office shall establish standards for consumer protection, including the following:

(1) Quality of care standards.

(2) A uniform process for participant grievances and appeals.

(3) Standardized reporting concerning provider performance, consumer experience, and cost.

(g) A health care provider that provides care to an individual who receives health insurance coverage under the plan shall participate in

the Medicaid program under IC 12-15.

(h) The office of the secretary may refer an individual who:

(1) has applied for health insurance coverage under the plan; and

(2) is at high risk of chronic disease;

to the Indiana comprehensive health insurance association for administration of the individual's plan benefits under IC 27-8-10.1.

(i) The following do not apply to the plan:

(1) IC 12-15-6.
(2) IC 12-15-12.
(3) IC 12-15-13.
(4) IC 12-15-14.
(5) IC 12-15-15.
(6) IC 12-15-21.
(7) IC 12-15-26.
(8) IC 12-15-31.1.
(9) IC 12-15-34.
(10) IC 12-15-35.
(11) IC 12-15-35.5.
(12) IC 16-42-22-10.

As added by P.L.218-2007, SEC.22.

IC 12-15-44-4 Version a

Services included in plan

Note: This version of section added by P.L.218-2007, SEC.22. See also following version of this chapter added by P.L.234-2007, SEC.210.

Sec. 4. (a) The plan must include the following in a manner and to the extent determined by the office:

(1) Mental health care services.
(2) Inpatient hospital services.
(3) Prescription drug coverage.
(4) Emergency room services.
(5) Physician office services.
(6) Diagnostic services.
(7) Outpatient services, including therapy services.
(8) Comprehensive disease management.
(9) Home health services, including case management.
(10) Urgent care center services.
(11) Preventative care services.
(12) Family planning services:

(A) including contraceptives and sexually transmitted disease testing, as described in federal Medicaid law (42 U.S.C. 1396 et seq.); and

(B) not including abortion or abortifacients.

(13) Hospice services.
(14) Substance abuse services.

(b) The plan must do the following:

(1) Offer coverage for dental and vision services to an individual who participates in the plan.

(2) Pay at least fifty percent (50%) of the premium cost of dental and vision services coverage described in subdivision (1).

(c) An individual who receives the dental or vision coverage offered under subsection (b) shall pay an amount determined by the office for the coverage. The office shall limit the payment to not more than five percent (5%) of the individual's annual household income. The payment required under this subsection is in addition to the payment required under section 11(b)(2) of this chapter for coverage under the plan.

(d) Vision services offered by the plan must include services provided by an optometrist.

(e) The plan must comply with any coverage requirements that apply to an accident and sickness insurance policy issued in Indiana.

(f) The plan may not permit treatment limitations or financial requirements on the coverage of mental health care services or substance abuse services if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

As added by P.L.218-2007, SEC.22.

IC 12-15-44-5 Version a

Preventative care

Note: This version of section added by P.L.218-2007, SEC.22. See also following version of this chapter added by P.L.234-2007, SEC.210.

Sec. 5. (a) The office shall provide to an individual who participates in the plan a list of health care services that qualify as preventative care services for the age, gender, and preexisting conditions of the individual. The office shall consult with the federal Centers for Disease Control and Prevention for a list of recommended preventative care services.

(b) The plan shall, at no cost to the individual, provide payment for not more than five hundred dollars ($500) of qualifying preventative care services per year for an individual who participates in the plan. Any additional preventative care services covered under the plan and received by the individual during the year are subject to the deductible and payment requirements of the plan.

As added by P.L.218-2007, SEC.22.

IC 12-15-44-6 Version a

Coverage limitations

Note: This version of section added by P.L.218-2007, SEC.22. See also following version of this chapter added by P.L.234-2007, SEC.210.

Sec. 6. The plan has the following per participant coverage limitations:

(1) An annual individual maximum coverage limitation of three hundred thousand dollars ($300,000).

(2) A lifetime individual maximum coverage limitation of one

million dollars ($1,000,000).
As added by P.L.218-2007, SEC.22.

IC 12-15-44-7 Version a
Use of appropriated funds

Note: This version of section added by P.L.218-2007, SEC.22. See also following version of this chapter added by P.L.234-2007, SEC.210.

Sec. 7. The following requirements apply to funds appropriated by the general assembly to the plan:

(1) At least eighty-five percent (85%) of the funds must be used to fund payment for health care services.

(2) An amount determined by the office of the secretary to fund:

(A) administrative costs of; and

(B) any profit made by;

an insurer or a health maintenance organization under a contract with the office to provide health insurance coverage under the plan. The amount determined under this subdivision may not exceed fifteen percent (15%) of the funds.

As added by P.L.218-2007, SEC.22.

IC 12-15-44-8 Version a
Not an entitlement; maximum enrollment

Note: This version of section added by P.L.218-2007, SEC.22. See also following version of this chapter added by P.L.234-2007, SEC.210.

Sec. 8. The plan is not an entitlement program. The maximum enrollment of individuals who may participate in the plan is dependent on funding appropriated for the plan.
As added by P.L.218-2007, SEC.22.

IC 12-15-44-9 Version a
Eligibility requirements

Note: This version of section added by P.L.218-2007, SEC.22. See also following version of this chapter added by P.L.234-2007, SEC.210.

Sec. 9. (a) An individual is eligible for participation in the plan if the individual meets the following requirements:

(1) The individual is at least eighteen (18) years of age and less than sixty-five (65) years of age.

(2) The individual is a United States citizen and has been a resident of Indiana for at least twelve (12) months.

(3) The individual has an annual household income of not more than two hundred percent (200%) of the federal income poverty level.

(4) The individual is not eligible for health insurance coverage through the individual's employer.

(5) The individual has not had health insurance coverage for at least six (6) months.

(b) The following individuals are not eligible for the plan:

(1) An individual who participates in the federal Medicare program (42 U.S.C. 1395 et seq.).

(2) A pregnant woman for purposes of pregnancy related services.

(3) An individual who is eligible for the Medicaid program as a disabled person.

(c) The eligibility requirements specified in subsection (a) are subject to approval for federal financial participation by the United States Department of Health and Human Services.

As added by P.L.218-2007, SEC.22.

IC 12-15-44-10 Version a

Health care account; funding

Note: This version of section added by P.L.218-2007, SEC.22. See also following version of this chapter added by P.L.234-2007, SEC.210.

Sec. 10. (a) An individual who participates in the plan must have a health care account to which payments may be made for the individual's participation in the plan only by the following:

(1) The individual.

(2) An employer.

(3) The state.

(b) The minimum funding amount for a health care account is the amount required under section 11 of this chapter.

(c) An individual's health care account must be used to pay the individual's deductible for health care services under the plan.

(d) An individual may make payments to the individual's health care account as follows:

(1) An employer withholding or causing to be withheld from an employee's wages or salary, after taxes are deducted from the wages or salary, the individual's contribution under this chapter and distributed equally throughout the calendar year.

(2) Submission of the individual's contribution under this chapter to the office to deposit in the individual's health care account in a manner prescribed by the office.

(3) Another method determined by the office.

(e) An employer may make, from funds not payable by the employer to the employee, not more than fifty percent (50%) of an individual's required payment to the individual's health care account.

As added by P.L.218-2007, SEC.22.

IC 12-15-44-11 Version a

Participation requirements; contributions to health care account; nonpayment

Note: This version of section added by P.L.218-2007, SEC.22. See also following version of this chapter added by P.L.234-2007, SEC.210.

Sec. 11. (a) An individual's participation in the plan does not begin until an initial payment is made for the individual's participation in the plan. A required payment to the plan for the

individual's participation may not exceed one-twelfth (1/12) of the annual payment required under subsection (b).

(b) To participate in the plan, an individual shall do the following:

(1) Apply for the plan on a form prescribed by the office. The office may develop and allow a joint application for a household.

(2) If the individual is approved by the office to participate in the plan, contribute to the individual's health care account the lesser of the following:

(A) One thousand one hundred dollars ($1,100) per year, less any amounts paid by the individual under the:

(i) Medicaid program under IC 12-15;

(ii) children's health insurance program under IC 12-17.6; and

(iii) Medicare program (42 U.S.C. 1395 et seq.);

as determined by the office.

(B) Not more than the following applicable percentage of the individual's annual household income per year, less any amounts paid by the individual under the Medicaid program under IC 12-15, the children's health insurance program under IC 12-17.6, and the Medicare program (42 U.S.C. 1395 et seq.) as determined by the office:

(i) two percent (2%) of the individual's annual household income per year if the individual has an annual household income of not more than one hundred percent (100%);

(ii) three percent (3%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred percent (100%) and not more than one hundred twenty-five percent (125%);

(iii) four percent (4%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred twenty-five percent (125%) and not more than one hundred fifty percent (150%); or

(iv) five percent (5%) of the individual's annual household income per year if the individual has an annual household income of more than one hundred fifty percent (150%) and not more than two hundred percent (200%);

of the federal income poverty level.

(c) The state shall contribute the difference to the individual's account if the individual's payment required under subsection (b)(2) is less than one thousand one hundred dollars ($1,100).

(d) If an individual's required payment to the plan is not made within sixty (60) days after the required payment date, the individual may be terminated from participation in the plan. The individual must receive written notice before the individual is terminated from the plan.

(e) After termination from the plan under subsection (d), the individual may not reapply to participate in the plan for twelve (12) months.

As added by P.L.218-2007, SEC.22.

IC 12-15-44-12 Version a

Plan period; renewal; termination; refund of payments to health care account

Note: This version of section added by P.L.218-2007, SEC.22. See also following version of this chapter added by P.L.234-2007, SEC.210.

Sec. 12. (a) An individual who is approved to participate in the plan is eligible for a twelve (12) month plan period. An individual who participates in the plan may not be refused renewal of participation in the plan for the sole reason that the plan has reached the plan's maximum enrollment.

(b) If the individual chooses to renew participation in the plan, the individual shall complete a renewal application and any necessary documentation, and submit to the office the documentation and application on a form prescribed by the office.

(c) If the individual chooses not to renew participation in the plan, the individual may not reapply to participate in the plan for at least twelve (12) months.

(d) Any funds remaining in the health care account of an individual who renews participation in the plan at the end of the individual's twelve (12) month plan period must be used to reduce the individual's payments for the subsequent plan period. However, if the individual did not, during the plan period, receive all qualified preventative services recommended as provided in section 5 of this chapter, the state's contribution to the health care account may not be used to reduce the individual's payments for the subsequent plan period.

(e) If an individual is no longer eligible for the plan, does not renew participation in the plan at the end of the plan period, or is terminated from the plan for nonpayment of a required payment, the office shall, not more than sixty (60) days after the last date of participation in the plan, refund to the individual the amount determined under subsection (f) of any funds remaining in the individual's health care account as follows:

(1) An individual who is no longer eligible for the plan or does not renew participation in the plan at the end of the plan period shall receive the amount determined under STEP FOUR of subsection (f).

(2) An individual who is terminated from the plan due to nonpayment of a required payment shall receive the amount determined under STEP FIVE of subsection (f).

(f) The office shall determine the amount payable to an individual described in subsection (e) as follows:

STEP ONE: Determine the total amount paid into the individual's health care account under section 10(d) of this chapter.

STEP TWO: Determine the total amount paid into the individual's health care account from all sources.

STEP THREE: Divide STEP ONE by STEP TWO.

STEP FOUR: Multiply the ratio determined in STEP THREE by the total amount remaining in the individual's health care account.

STEP FIVE: Multiply the amount determined under STEP FOUR by seventy-five hundredths (0.75).

As added by P.L.218-2007, SEC.22.

IC 12-15-44-13 Version a

Payment for nonemergency services in emergency room

Note: This version of section added by P.L.218-2007, SEC.22. See also following version of this chapter added by P.L.234-2007, SEC.210.

Sec. 13. Subject to appeal to the office, an individual may be held responsible under the plan for receiving nonemergency services in an emergency room setting, including prohibiting the individual from using funds in the individual's health care account to pay for the nonemergency services. However, an individual may not be prohibited from using funds in the individual's health care account to pay for nonemergency services provided in an emergency room setting for a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

(1) place an individual's health in serious jeopardy;

(2) result in serious impairment to the individual's bodily functions; or

(3) result in serious dysfunction of a bodily organ or part of the individual.

As added by P.L.218-2007, SEC.22.

IC 12-15-44-14 Version a

Claim processing; provider reimbursement; cultural competency

Note: This version of section added by P.L.218-2007, SEC.22. See also following version of this chapter added by P.L.234-2007, SEC.210.

Sec. 14. (a) An insurer or health maintenance organization that contracts with the office to provide health insurance coverage, dental coverage, or vision coverage to an individual that participates in the plan:

(1) is responsible for the claim processing for the coverage;

(2) shall reimburse providers at a reimbursement rate of:

(A) not less than the federal Medicare reimbursement rate for the service provided; or

(B) at a rate of one hundred thirty percent (130%) of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate; and

(3) may not deny coverage to an eligible individual who has been approved by the office to participate in the plan, unless the

individual has met the coverage limitations described in section 6 of this chapter.

(b) An insurer or a health maintenance organization that contracts with the office to provide health insurance coverage under the plan must incorporate cultural competency standards established by the office. The standards must include standards for non-English speaking, minority, and disabled populations.

As added by P.L.218-2007, SEC.22.

IC 12-15-44-15 Version a

Offer of coverage to eligible individuals when maximum enrollment reached

Note: This version of section added by P.L.218-2007, SEC.22. See also following version of this chapter added by P.L.234-2007, SEC.210.

Sec. 15. (a) An insurer or a health maintenance organization that contracts with the office to provide health insurance coverage under the plan or an affiliate of an insurer or a health maintenance organization that contracts with the office to provide health insurance coverage under the plan shall offer to provide the same health insurance coverage to an individual who:

(1) has not had health insurance coverage during the previous six (6) months; and

(2) meets the eligibility requirements specified in section 9 of this chapter for participation in the plan but is not enrolled because the plan has reached maximum enrollment.

(b) The insurance underwriting and rating practices applied to health insurance coverage offered under subsection (a) must not be different from underwriting and rating practices used for the health insurance coverage provided under the plan.

(c) The state does not provide funding for health insurance coverage received under this section.

As added by P.L.218-2007, SEC.22.

IC 12-15-44-16 Version a

Offer of coverage to ineligible individuals

Note: This version of section added by P.L.218-2007, SEC.22. See also following version of this chapter added by P.L.234-2007, SEC.210.

Sec. 16. (a) An insurer or a health maintenance organization that contracts with the office to provide health insurance coverage under the plan or an affiliate of an insurer or a health maintenance organization that contracts with the office to provide health insurance coverage under the plan shall offer to provide the same health insurance coverage to an individual who:

(1) has not had health insurance coverage during the previous six (6) months; and

(2) does not meet the eligibility requirements specified in section 9 of this chapter for participation in the plan.

(b) An insurer, a health maintenance organization, or an affiliate

described in subsection (a) may apply to health insurance coverage offered under subsection (a) the insurer's, health maintenance organization's, or affiliate's standard individual or small group insurance underwriting and rating practices.

(c) The state does not provide funding for health insurance coverage received under this section.

As added by P.L.218-2007, SEC.22.

IC 12-15-44-17 Version a

Indiana check-up fund

Note: This version of section added by P.L.218-2007, SEC.22. See also following version of this chapter added by P.L.234-2007, SEC.210.

Sec. 17. (a) The Indiana check-up plan trust fund is established for the following purposes:

(1) Administering a plan created by the general assembly to provide health insurance coverage for low income residents of the state under this chapter.

(2) Providing copayments, preventative care services, and premiums for individuals enrolled in the plan.

(3) Funding tobacco use prevention and cessation programs, childhood immunization programs, and other health care initiatives designed to promote the general health and well being of Indiana residents.

The fund is separate from the state general fund.

(b) The fund shall be administered by the office of the secretary of family and social services.

(c) The expenses of administering the fund shall be paid from money in the fund.

(d) The fund shall consist of the following:

(1) Cigarette tax revenues designated by the general assembly to be part of the fund.

(2) Other funds designated by the general assembly to be part of the fund.

(3) Federal funds available for the purposes of the fund.

(4) Gifts or donations to the fund.

(e) The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public money may be invested.

(f) Money must be appropriated before funds are available for use.

(g) Money in the fund does not revert to the state general fund at the end of any fiscal year.

(h) The fund is considered a trust fund for purposes of IC 4-9.1-1-7. Money may not be transferred, assigned, or otherwise removed from the fund by the state board of finance, the budget agency, or any other state agency.

As added by P.L.218-2007, SEC.22.

IC 12-15-44-18 Version a

Requirements for implementation

Note: This version of section added by P.L.218-2007, SEC.22. See also following version of this chapter added by P.L.234-2007, SEC.210.

Sec. 18. (a) The office may not:

(1) enroll applicants;

(2) approve any contracts with vendors to provide services or administer the plan;

(3) incur costs other than costs necessary to study and plan for the implementation of the plan; or

(4) create financial obligations for the state;

unless both of the conditions of subsection (b) are satisfied.

(b) The office may not take any action described in subsection (a) unless:

(1) there is a specific appropriation from the general assembly to implement the plan; and

(2) after review by the budget committee, the budget agency approves an actuarial analysis that reflects a determination that sufficient funding is reasonably estimated to be available to operate the plan for at least the following five (5) years.

The actuarial analysis approved under subdivision (2) must clearly indicate the cost and revenue assumptions used in reaching the determination.

(c) The office may not operate the plan in a manner that would obligate the state to financial participation beyond the level of state appropriations authorized for the plan.

As added by P.L.218-2007, SEC.22.

IC 12-15-44-19 Version a

Rules

Note: This version of section added by P.L.218-2007, SEC.22. See also following version of this chapter added by P.L.234-2007, SEC.210.

Sec. 19. (a) The office may adopt rules under IC 4-22-2 necessary to implement this chapter.

(b) The office may adopt emergency rules under IC 4-22-2-37.1 to implement the plan on an emergency basis.

(c) Notwithstanding IC 12-8-1-9 and IC 12-8-3, rules adopted under this section before January 1, 2009, are not subject to review or approval by the family and social services committee established by IC 12-8-3-2. This subsection expires December 31, 2009.

As added by P.L.218-2007, SEC.22.

IC 12-15-44-20 Version a

Premium assistance program

Note: This version of section added by P.L.218-2007, SEC.22. See also following version of this chapter added by P.L.234-2007, SEC.210.

Sec. 20. (a) The office may establish a health insurance coverage premium assistance program for individuals who:

(1) have an annual household income of not more than two

hundred percent (200%) of the federal income poverty level; and

(2) are eligible for health insurance coverage through an employer but can not afford the health insurance coverage premiums.

(b) A program established under this section must:

(1) contain eligibility requirements that are similar to the eligibility requirements of the plan;

(2) include a health care account as a component; and

(3) provide that an individual's payment:

(A) to a health care account; or

(B) for a health insurance coverage premium;

may not exceed five percent (5%) of the individual's annual income.

As added by P.L.218-2007, SEC.22.

IC 12-15-44-21 Version a

Federal approval; severability

Note: This version of section added by P.L.218-2007, SEC.22. See also following version of this chapter added by P.L.234-2007, SEC.210.

Sec. 21. A denial of federal approval and federal financial participation that applies to any part of this chapter does not prohibit the office from implementing any other part of this chapter that:

(1) is federally approved for federal financial participation; or

(2) does not require federal approval or federal financial participation.

As added by P.L.218-2007, SEC.22.

IC 12-15-44 Version b

Chapter 44. Coordination of Benefits Study

Note: This version of chapter added by P.L.234-2007, SEC.210. See also preceding version of this chapter added by P.L.218-2007, SEC.22.

IC 12-15-44-1 Version b

Covered entity

Note: This version of section added by P.L.234-2007, SEC.210. See also preceding version of this chapter added by P.L.218-2007, SEC.22.

Sec. 1. As used in this chapter, "covered entity" has the meaning set forth in 45 CFR 160.103.

As added by P.L.234-2007, SEC.210.

IC 12-15-44-2 Version b

Analysis of claims

Note: This version of section added by P.L.234-2007, SEC.210. See also preceding version of this chapter added by P.L.218-2007, SEC.22.

Sec. 2. (a) Before January 1, 2008, the office shall do the

following:

(1) Examine all Medicaid claims paid after January 1, 2001, and before July 1, 2007.

(2) Determine the claims examined under subdivision (1) that were eligible for payment by a third party other than Medicaid.

(3) Recover the costs associated with the claims determined under subdivision (2) to be eligible for payment by a third party other than Medicaid.

(b) If the office requests a covered entity to furnish information to complete the examination required by this section, the covered entity shall furnish the requested information to the office.

As added by P.L.234-2007, SEC.210.

IC 12-15-44-3 Version b

Release of human identifier information; determination of eligibility

Note: This version of section added by P.L.234-2007, SEC.210. See also preceding version of this chapter added by P.L.218-2007, SEC.22.

Sec. 3. (a) The office is authorized to transmit the minimum human identifiers in ANSI X.12 270 inquiries, including the name, gender, and date of birth of a Medicaid recipient, to a covered entity licensed or registered to provide health insurance or health care coverage to Indiana residents for the purpose of establishing the coverage in force of a Medicaid recipient who presents a claim.

(b) A health plan that receives a message described in subsection (a) from the office or its agent shall respond to the office or its agent within twenty-four (24) hours.

(c) An entity licensed or registered to provide health insurance or health care coverage to Indiana residents that refuses an ANSI X. 12 270 message described in subsection (a) that was transmitted to the entity by the office or its agent is subject to a fine for each refusal in an amount not to exceed one thousand dollars ($1,000) for each refusal.

(d) The office may impose the fine described in subsection (c).

As added by P.L.234-2007, SEC.210.

IC 12-15-44-4 Version b

Enforcement; injunctive relief; costs

Note: This version of section added by P.L.234-2007, SEC.210. See also preceding version of this chapter added by P.L.218-2007, SEC.22.

Sec. 4. The office, any medical provider wishing to bill Indiana Medicaid, or any health plan has a cause of action for injunctive relief against any health plan that fails to comply with this chapter. A plaintiff seeking relief under this section may recover costs of litigation, including attorney's fees.

As added by P.L.234-2007, SEC.210.

IC 12-15-44-5 Version b

Enforcement; attorney general

Note: This version of section added by P.L.234-2007, SEC.210. See also preceding version of this chapter added by P.L.218-2007, SEC.22.

Sec. 5. If the office or its agent furnishes evidence that a health plan has refused or failed to respond to messages described in section 3(a) of this chapter transmitted by the office or its agent to the health plan, the attorney general shall:

(1) subpoena the enrollment data of any entity that refuses or fails to respond to the messaging described in section 3(a) of this chapter;

(2) commence a complaint under 42 U.S.C. 1320d-5 for administrative sanctions under the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191); and

(3) commence a prosecution under USC 1035 or IC 5-11-5.5 of any entity that refuses or fails to respond to the messaging described under section 3(a) of this chapter.

As added by P.L.234-2007, SEC.210.

IC 12-15-44-6 Version b

Implementation of procedures to coordinate benefit payments

Note: This version of section added by P.L.234-2007, SEC.210. See also preceding version of this chapter added by P.L.218-2007, SEC.22.

Sec. 6. (a) If, after the office completes its examination under section 2 of this chapter, the office determines that the number of claims determined under section 2(a)(2) of this chapter is at least one percent (1%) of the number of claims examined under section 2(a)(1) of this chapter, the office shall develop and implement a procedure to improve the coordination of benefits between:

(1) the Medicaid program; and

(2) entities that provide health coverage to a Medicaid recipient.

(b) If a procedure is developed and implemented under subsection (a), the procedure:

(1) must be automated; and

(2) must have the capability to determine whether a Medicaid claim is eligible for payment by an entity other than the Medicaid program before the claim is paid under the Medicaid program.

As added by P.L.234-2007, SEC.210.